Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

ACCUMULATED LEAVE CERTIFICATION

Wis. Stat. § 40.05 (4) (b) and Wis. Stat. § 40.02 (25) (b) and (bc)

Complete this form for each terminating employee who:

1. Is age 55 or over (age 50 if protective occupation); OR
2. Is applying for a disability benefit; OR
3. Died; OR
4. Qualifies for delayed sick leave usage under 1991 WA 39 (Public Official); OR
5. Qualifies for delayed sick leave usage under 2003 WA 33 (Employee terminating after 20 years service but not eligible for immediate annuity)

THIS FORM MUST BE SUBMITTED WITHIN 30 DAYS AFTER TERMINATION. DO NOT SUBMIT BEFORE TERMINATION. TYPE OR PRINT IN INK.

EMPLOYEE INFORMATION

Name (Last, First, Middle, Former)	Social Security Number	Birthdate (MM/DD/YY)

Address (Street or P.O. Box No., City, State, Zip Code)	Employment Category
	☐ Non-Teacher ☐ Teacher

Gender	Termination Date or Date of Death (MM/DD/YY)	Reason for Termination *(see above)*
☐ Male ☐ Female	/ /	1 ☐ Retirement - Eligible 3 ☐ Death 5 ☐ WA 33 2 ☐ Retirement-Disabled 4 ☐ WA 39

Position Title

Does employee have state health insurance coverage?	Is spouse employed by State of Wisconsin?	Is employee a dependent on spouse's STATE contract?
☐ Yes ☐ No	☐ Yes ☐ No ☐ Don't Know ☐ N/A	☐ Yes ☐ No ☐ Don't Know

HEALTH PLAN INFORMATION (Complete Spouse's health plan information if employee is a dependent on spouse's state contract)

Health Plan	Health Plan Code	Coverage Type	Group No.
		☐ Single ☐ Family	

SPOUSE/DEPENDENT INFORMATION

Name (Last, First, Middle, Former)	Social Security Number	Birthdate (MM/DD/YY)

CERTIFICATION OF ACCUMULATED LEAVE

a) Enter unused sick leave hours (enter Ø if none)	
b) Add other creditable leave hours (see instructions in Health Insurance Manual)	
c) Total Hours (a + b)	
d) Highest Basic Pay Rate as State Employee	$
e) Amount Certified (c x d)	$

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Seniority Date:		Bargaining Unit:	
Years of service equal to or less than 24			
Years of service greater than 24			

f) Enter Supplemental Sick Leave hours (include extra 500 hours if applicable)	
g) Highest Basic Pay Rate as State Employee*	$
h) Amount certified (f x g)	$
Enter a **Y** in the box if the extra 500 hours are included	
TOTAL AMOUNT CERTIFIED (e + h)	$
Premiums have been paid for coverage through (MM/YY)	/

* **NOTE:** In most cases the highest basic pay will be used, however there are some exceptions. Please refer to current bargaining agreements for represented employees. For some employees line g) will be calculated using the ending base pay rate, or, at the employee's request, the average of the employee's base pay rates during the three highest years. Contact the Office of State Employment Relations for clarification.

EMPLOYER INFORMATION

	Group No.

Date (MM/DD/YY) // //	Signature of Agent	Contact Name and Phone	Employer Name

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Effec. Date (MM/YY)	Coverage Type	Premium Amount
/		

Submit to ETF at above address.
Keep a copy for your records.